

## **Vision Benefits – Claim Instructions**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

#### TO THE EMPLOYEE

- 1. Complete items one (1) through twenty-seven (27) in full. Be certain to sign the authorization to release information block (28).
- 2. If you wish to have your benefits for this claim paid directly to the doctor and/or dispenser, sign the block (29).
- 3. If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
- 4. Incomplete forms will delay payment
- 5. Send the completed benefits request and the bills to the Aetna office that services your employer.

#### TO THE DOCTOR

- 1. Complete items thirty (30) through forty-three (43) in full.
- 2. If the employee indicates that benefits should be paid directly to the doctor, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

### TO THE DISPENSER

- 1. Complete items forty-four (44) through fifty-three (53) in full.
- 2. If the employee indicates that benefits should be paid directly to the dispenser, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

GC-10 (4-03)



# Vision Benefits Request

TO BE COMP	LETED BY EMPLOYEE								
Employer's Name								Policy/Group Number Bra	anch Number
3. Employee's	Employee's Social Security Number 4. Employee's Name							Employee's Birthdate (MM/DD/YYYY)	
_	re Retired	de zip code)				8	B. Employee's Daytime Telepho	one Number	
9. Patient's Name 10. Patient's Social			Security Number		11. Patient's Birt	hdate (MM/DD/YYYY)	12. Patient's Relatio		Other
13. Patient's Address (if different from employee)  14. Patient's Sex  ☐ Male ☐ Fe					16. Patient's Exp	16. Patient's Expected Graduation Date 17. Name of School City			
18. Patient's Marital Status 19. Is patient emplo Married ☐ Single ☐ No ☐			yed? Yes		20. Name & Address of Employer				
21. Are any far Cross-Blue	mily members expenses covered by Shield, etc.), no fault auto insuran	up pre-payment plan (Blue te or local government plan? 22. If yes, list policy company or adi			licy or contract holder, po administrator:	y or contract holder, policy or contract number(s) and name/address of insurance ministrator:			
23. Member's			l			25. Member's Birthdate (MM	M/DD/YYYY)		
26. Is claim related to an accident?  No Yes If yes, date			time			am pi	n	27. Is claim related to emplo	oyment?
profession (including above with wallid for that a phenomena)	authorized to provide Aetha onals and utilization review of that relating to mental illuith any benefit calculation u the term of the policy or co otographic copy of this auth or Authorized Person's Sig-	organizations with whom ness and/or AIDS/ARC/F used in payment of this clue outract under which a clai norization is as valid as the nature	Aetna has con IIV). This infor him for the purp m has been sub the original.	tracted, information will pose of rev	formation cond Il be used to evriewing the exp	cerning health care a valuate claims for be perience and operation	dvice, treatment nefits. Aetna ma on of the policy of	or supplies provided the y provide the employer for contract. This authorize	e patient named zation is and agree
	ze payment of vision care b or Authorized Person's Sign		or dispenser.					Date	
	MPLETED BY PHYSICIAN O								
30. Doctor's Na	ame & Address (include zip code)		31. Telephone	Number		You are required in number.	under authority of law	o be used for 1099 reporting pr to furnish your taxpayer identi	
	33. Title 34. Examinatio M.D. D.O. O.D.								
	performed?		better ey	al acuity be restored to 20/70 in e with conventional eyeglasses?  Yes		<ol> <li>Does patient require a prescription change at this time?</li> <li>No Yes</li> </ol>			
38. Diagnostic	Code(s)			, 100				110 [] 100	
39. Indicate dia	agnosis or nature of disease or inju	ry or vision disorder, indicate pr	ocedure code numbers				40. Visual acuity corrected to		
41. Doctor's Pr	escription Sphere	Cylinder	Axis	Prism	Base	42. Professional Serv Exam (HCPC/CP		Amount \$	1
R.E.	sphere •	• Cylinder	AAIS	1 115111	Dase	Sales Tax (if			_
L.E.	•	•				]		otal \$	<u> </u>
	Reading Add	R.E.	+ •	L.E.	+ •		ount Paid by Patio		
Doctor's	rtify that the procedures as indicate Signature							for those procedures.  Date	
Note: In lieu o	of dispenser completing this se	ction a laboratory bill can be	attached. Disper	nser must siç	gn this form, ent	er amount paid by pation	ent.		
44. Dispenser's	s Name & Address (include zip cod	le)	45. Telephone	Number				o be used for 1099 reporting p to furnish your taxpayer identi	
	47. Title Optician Optometrist Ophthalmologist								
			48. Date Order Delivery					Oversized Tint #_Other_	
			nses, please complete Deutic (HCPC/CPT)			52. Professional	Service Lens Char	Amount sge \$	
			Therapeutic (HCPC/CPT)				Frame Charge \$		
☐ Bifocal (HCPC/CPT) ☐ Hard I			enses (HCPC/CPT)			Optional	Le	ens \$	
Trifocal (HCPC/CPT)		Soft Le	Soft Lenses (HCPC/CPT)				Fra		
Lenticular (HCPC/CPT)  Contacts (HCPC/CPT)									<u> </u>
			51a. If frames, please complete				Sales Tax (if any) \$		
	(specify below) (HCPC/CP		Frames (HCPC/CPT)				To	otal \$	<u> </u>
L							unt Paid By Pati	-	
	rtify that I have performed the servi	ices as indicated hereon and the	at the fees submitte	d are the actu	ual fees I have cha	rged this patient and inte		e procedures. Date	